Navy Environmental Health Center
Technical Manual NEHC – TM 6100.99-9A (July 2000)

U.S. Navy HIV Instructor Course

Sexual Health and Responsibility Program

NAVY ENVIRONMENTAL HEALTH CENTER

BUREAU OF MEDICINE AND SURGERY

ACKNOWLEDGMENTS

This booklet is a component of the Sexual Health and Responsibility Program (SHARP), which replaced the HIV Education Program formerly located at the National Naval Medical Center (NNMC) Bethesda, MD. It was developed in cooperation with Navy medical practitioners, the staff of the Navy Central HIV Program, and the staff at the Naval Bureau of Personnel (N130H).

Reviewed and Approved

D. M. Sack
Commanding Officer

Views and opinions expressed are not necessarily those of the Department of the Navy.

Statement of Changes:

Technical Manual Title NEHC--TM 6100.99-9 (September 1999)
Change: Technical Manual NEHC TM 6100.99-9A (July 2000)

Inside Cover
Change: Signature of new Commanding Officer

Page 3: Completion of registration and exam
Change: Instructions updated to reflect the option of on-line examination

Page 4: Description of Navy HIV program
Change: Deleted the reference to NNMC program and updated reference to major web site topics

Page 7: MCO 6200.44
Change: Semper Fit program renumbered to MCO P1700.29, 8 Nov 99

Page 9: 50 cases of HIV transmission between patients and HCWs
Change: Centers for Disease Control and Prevention cites 56 cases currently

Page 12, Paragraph 3: Reference to HIV-positive personnel going TAD on board naval vessels
Change: BUPERS has deleted any exceptions for HIV-positive personnel going TAD on board vessels; first two sentences deleted. Statement about SOFA moved to page 7, paragraph 3.

Page 13: Added chart-Number of HIV-positive sailors and marines on active duty

Page 19, Paragraph 2: Issue of HIV-positive personnel on TDRL who are reevaluated and brought back on active duty.
Change: There has been no new policy statement issued pertaining to HIV status and TDRL; the standard remains whether the medical authority evaluates the member as "fit for duty"

Page 23: Added chart-Numbers of seroconversions by Service and year

Page 26, Paragraph 1: 10% of female recruits were found to have chlamydia
Change: Qualify that this was one study and true prevalence may be lower

Pages 42-45: Preventive Medicine Letters, paragraph f.
Change: Insert current versions which clarify the TAD restriction on board vessels or to deployed settings

Page 49, question 20
Change: New question

Page 50, question 25
Change: New question

Table of Contents

Navy HIV Instructor Course

This revision replaces all previous editions of the Navy HIV Instructor Course. This course covers Navy-specific information. It is designed to inform prospective Navy HIV Instructors of current policies and procedures that apply to Navy and Marine Corps personnel infected with HIV and will enable instructors to discuss the issues surrounding HIV from a military perspective. This course may be taken in conjunction with other course material, such as the American Red Cross (ARC) Instructor modules, or may be completed as a separate study session. Both this course and additional study on the pathophysiology of AIDS is required for personnel to provide training to Navy and Marine Corps personnel on this subject. Additional study must cover pathology, modes of transmission, treatments, and prevention strategies. This course is not intended to be used to fulfill the 1-hour annual requirement for General Military Training (GMT).

To receive a Navy Instructor Certificate, participants must:

a) possess academic training on the pathophysiology of AIDS (e.g., American Red Cross HIV Instructors; instructors trained through State or Centers for Disease Control HIV programs; credentialed health care professionals such as physicians, physician assistants, nurses, certified Emergency Medical Technicians; or Navy Preventive Medicine Technicians who have received specialized training in HIV counseling skills)
b) complete this course and the post-course exam
c) complete the on-line HIV Instructor Registration and Exam Personnel may also forward the completed exam, either by e-mail (see the SHARP web site at www-nehc.med.navy.mil/hp) or by hard-copy mail to the Navy Environmental Health Center (NEHC) at:

COMMANDING OFFICER
NAVY ENVIRONMENTAL HEALTH CENTER
ATTN: HP (SHARP)
2510 WALMER AVENUE
NORFOLK, VA 23513-2617

Results of the exam will immediately be reported directly to the instructor candidate and HIV Area Coordinator and a certificate will be awarded for satisfactory completion. Trained HIV instructors are encouraged to utilize their certification in support of training requirements for active duty personnel and other Navy beneficiaries such as Navy civilian employees, child development services, and teens.

Comments on this course or additional training needs are encouraged and can be forwarded to the SHARP Program Manager.

Unit 1: Sexual Health and Responsibility Program (SHARP)

MISSION STATEMENT

To promote combat readiness and maintain morale within Navy and Marine Corps commands by maintaining optimal sexual health of personnel

Goals

To provide educational programs and materials which inform personnel about HIV/STD
To teach skills which reduce risk of STD and unplanned pregnancy
To promote responsible sexual decision-making

The Navy's HIV Education Program has been integrated into the Health Promotion Directorate of the Navy Environmental Health Center (NEHC) as one of the major components of health promotion in both Navy Health Promotion and Marine Corps Semper Fit programs. The SHARP program seeks to reduce the occurrence of HIV, STDs, and other unplanned consequences associated with the sexual behavior. Specific objectives of SHARP are to:

1. Provide information, education, and behavior change programs on the prevention of HIV and other STDs to active duty personnel, family members and retirees, and other beneficiaries.
2. Target persons whose behavior puts them at higher risk of infection, e.g., STD clinic patients, drug and alcohol treatment participants, and patients attending family planning clinics. These programs will emphasize responsible decision-making and emphasize specific skill-building techniques.
3. Provide information and educational programs to health care providers and their patients as part of the Put Prevention Into Practice (PPIP) program, a program concerned with clinical preventive health care. The PPIP element will focus on conducting sexual risk assessments, providing effective counseling, and conveying risk reduction messages to patients.

The SHARP web site at www-nehc.med.navy.mil/hp contains a variety of information to include:

*Policy and program guidance
*Educational and training resources
*Navy HIV Instructor requirements and on-line registration
*HIV surveillance data
*Links to community resources

All HIV educators must register with NEHC and can do so on-line at this site.

In the past American Red Cross (ARC) HIV courses have been the sole tool utilized to provide instructors with 1) basic instruction theory, 2) factual, culturally sensitive, and non-judgmental information on HIV/AIDS, 3) logical structure for providing lessons to a variety of groups, and 4) supervised practice. Although these courses are not military-specific, they have provided a basic framework for educating our population.

SHARP will continue to facilitate the training of a core of instructor-trainers and instructors utilizing the ARC program. In addition, other effective courses and programs will be examined or developed to meet the educational directives of the SECNAV INSTRUCTION 5300 and other stated needs of the Navy.

SHARP has established a network of Area Coordinators (ACs), responsible for areas roughly corresponding to each of the Service Tricare Regions and assists them in maintaining a roster of qualified instructors and instructor-trainers. Area Coordinators help promote communication and a flow of information with personnel at the local level to include line commands, health promotion program managers, Preventive Medicine personnel, and HIV instructors by directing them to appropriate resources or the SHARP program staff. ACs may also assume instructor or instructor-trainer (IT) duties. ACs provide SHARP with consolidated quarterly reports of classes provided within their Tricare Regions from data provided by instructors.

ITs will continue to train prospective instructors as needed and as requested by commands, utilizing the ARC HIV Instructor program or other NEHC-approved courses as they become available. Each IT will provide SHARP with names and contact information of new instructors and will assist in the certification of additional instructor trainers.

Instructors will use approved lesson plans or materials when providing HIV/STD classes. They will report workload data to their AC after each class:

1. command/unit/or group name
2. number of personnel attending
3. date of class
4. Type session: (a) GMT, (b) AIDS in the Workplace; (c) Liberty briefing, or (d) Other.

Unit 2: Personnel Administration

1. Policy Guidelines

In the mid-1980's the Department of Defense realized that the newly recognized AIDS outbreak within the civilian community could have profound effects on military readiness. After all, military recruits are drawn from the civilian population. Due to the long period that infected persons remain asymptomatic, the possibility existed that new accessions could be infected when they entered military service.

A number of Defense Department publications reflected the urgency felt by the senior military leadership to address the potential impact of HIV on the military. The following examples are cited merely to illustrate the involvement of many DoD departments and the tremendous amount of work required to address the issue:

(1) Assistant Secretary of Defense (Health Affairs) Memorandum, "Military Implementation of Public Health Service Provisional Recommendations Concerning Testing Blood and Plasma for Antibodies to HTLV-III," July 17, 1985 (superceded by DoD Directive 6485.1)
(2) Assistant Secretary of Defense (Health Affairs) Memorandum, "DoD Reportable Disease Database," December 30, 1985
(3) DoD Directive 1332.18, "Separation from the Military Service by Reason of Physical Disability," February 25, 1986
(4) Assistant Secretary of Defense (Force Management and Personnel) Memorandum, "Information and Guidance on Human Immunodeficiency Virus (HIV)," January 22, 1988
(5) Chapter 47 of title 10, United States Code, "Uniform Code of Military Justice (UCMJ)"
(6) Federal Personnel Manual Bulletin 792-42, "AIDS in the Workplace," March 24, 1988
(7) DoD Instruction 1438.4, "Compliance with Host Nation Human Immunodeficiency Virus (HIV) Screening Requirements for DoD Civilian Employees," December 5, 1988 (superceded by DoD Directive 6485.1)
(8) Assistant Secretary of Defense (Health Affairs) Memorandum, "HIV Testing and Look Back Guidelines for Homologous Blood Donations," January 11, 1989

DoD Directive 6485.1, March 19, 1991

This publication directed the Services to update policy, responsibilities, and procedures for the identification, surveillance, and administration of civilian and military personnel infected with HIV-1 (hereafter referred to as HIV, unless otherwise noted). The Assistant Secretaries of Defense for Health Affairs, Force Management and Personnel, General Counsel, Reserve Affairs, and International Security Affairs each addressed specific portions of the program pertaining to their areas of responsibility.

Each Military Service (Army, Navy, Air Force, and Marine Corps) prepared a plan for implementing a comprehensive HIV/AIDS education program. Some Military Services began HIV education in conjunction with initial serologic force testing in 1985-86.

Each military medical service was prepared to conduct ongoing clinical evaluations of service members with serologic evidence of HIV infection, gather epidemiological data from those members to document how the infection was transmitted, and conduct ongoing research. The US military was thus in a very good position to conduct medical research on this problem, given that the military would continue to provide ongoing medical care to a large group of individuals.

Screening of DoD Civilian Employees was addressed because some host nations prescribe that any US personnel entering their country have documented sero-negative blood test results. Status of Forces Agreements (SOFA) may limit entry of HIV-positive personnel into foreign countries. For example, Japan does not allow US HIV-positive personnel to come ashore, although Spain does.

While DoD civilians cannot be ordered to have their blood tested, they will not be permitted to travel on orders to those countries that require a negative HIV blood test.

SECNAVINST 5300.30C (14 March 1990; replaced SECNAVINST 5300.30B)

SECNAVINST 5300.30 states the Department of the Navy's (DON) policy on identification, surveillance and administration of Navy and Marine Corps personnel infected with HIV.

SECNAV NOTICE 5300 (12 March 1996)

This notice discusses HIV training requirements and directs commands to conduct a minimum of 1-hour HIV/AIDS prevention education annually for military personnel and to make available training for DON civilian employees and their supervisors. It remains in effect until incorporated into the next revision of SECNAVINST 5300.

MARINE CORPS ORDER P1700.29 (8 Nov 1999)

The Marine Corps Health Promotion Program (SEMPER FIT) includes annual training on modes of transmission and prevention of STDs and HIV. STD/HIV prevention is one of the nine health promotion program elements of SEMPER FIT.

2. Rationale for the Navy HIV policies and procedures

DON policies are based on current knowledge of the natural history of HIV infection. Although the course of progression to AIDS is variable among individuals, on average there has been a period of 8 to 10 years from initial infection to clinical AIDS in adults. About 10% of persons have not progressed to AIDS even after 10 years. Military

personnel infected with HIV are medically evaluated. As with other medical conditions, retention is based on fitness for duty.

a. Health of Infected Personnel

One reason for instituting policies and procedures within the military is that the health of HIV-infected military personnel may be placed at risk as a result of their military service. Military personnel are subject to travel to underdeveloped and developing countries, where exposure to disease may be greater. These personnel may be more susceptible to numerous infections that can later cause serious disease. Also, they may not develop an adequate immune response after receiving vaccines designed to protect deployed forces and, thus, may not be protected by vaccines as well as other personnel. Some vaccines are "live virus" vaccines which are not given to persons whose immune systems are compromised, to include persons with HIV, since there is a risk of actually causing that disease in persons receiving the vaccine (Appendix 1). For example, oral polio vaccine and varicella (chickenpox) are not given to individuals infected with HIV. Other vaccines should still be administered to HIV-positive individuals. The anthrax vaccine is not a live virus vaccine, but is also not routinely given to HIV-infected personnel.

b. Effect on Unit Readiness

Policies have also been developed because of the impact of infected personnel on unit readiness. Naval units may be deployed on short notice to locations throughout the world for indefinite periods of time. During deployments commands may have little or no external support, but be expected to meet all the needs of their assigned personnel, and at the same time perform the missions assigned to them. In short, deployed naval units are manned to meet operational requirements and to be essentially self-sufficient. Medical conditions, to include HIV infection, which place additional requirements on the units or increase the likelihood that personnel shortages due to illness may occur, detract from their readiness status. Having said that, what is the likelihood that an HIV infected seaman would become ill, become exposed to anthrax spores, expose others to his or her blood, or require additional medical evaluation or treatment during a deployment? There are no definite answers to these questions. However, while recent wars have been relatively short and have relied on high-tech war fighting capabilities, this may not always be the case. Military leaders remain selective regarding the deployment of only those service members who have no physical impairments, which might interfere with their ability to accomplish the military mission, under prolonged conditions of hardship if necessary.

c. Risk of Transmission to Noninfected Personnel

There was also a concern about risk for transmission of HIV from infected personnel to noninfected personnel. Policies have been established within Navy medicine, both afloat and within fixed shore-based facilities, that comply with accepted medical practice (i.e., OSHA Blood Borne Pathogen Standard) for preventing exposure of medical staff, for preventing transmission from a health care provider to patients, for reporting exposures, and for providing post-exposure prophylaxis. The Navy adheres to Centers for Disease Control (CDC) Guidelines for anti-retroviral medication given after direct exposure to HIV. Exposures to contaminated body fluids, including blood, are uncommon when

"universal precautions/standard precautions" are taken. It is important to note that the transmission of HIV infection between patient and health care provider remains rare (56 documented HIV transmissions in the US through 1999). During the initial period of the epidemic, there was concern about battlefield injuries and the first-aid "buddy" system that could expose personnel to contaminated blood. However, the concern over HIV and other blood borne infections has prompted changes in first aid, CPR techniques, and medical procedures, which reduce direct contact with blood and body fluids. Of course, routine living accommodations on Navy vessels do not present a risk for HIV transmission. In summary, HIV is transmitted through contact with contaminated blood and body fluids, but not from casual contact.

d. Military Blood Supply

Other controls exercised through military medical channels include screening of the blood supply and testing of all active duty personnel and other identified risk groups, such as STD patients, drug and alcohol referrals, and pregnant women. In times of military conflict, blood supplies may come primarily from the assembled US military forces. All donated blood is routinely screened for both HIV and hepatitis B antibodies. In addition, if any donor seroconverts to HIV-positive after donating blood, all persons receiving that blood are contacted and screened for HIV as part of the "Lookback" program. Armed Services Blood Program policies, FDA guidelines, and accreditation requirements of the American Association of Blood Banks (AABB) are followed in the Department of the Navy blood program and by civilian blood agencies collecting blood on naval installations. The appearance of HIV has certainly strengthened both military and civilian blood donor programs, and eliminated as many donors as possible who could transmit blood borne pathogens, to include HIV.

e. Military Discipline

The greatest risk of exposure to HIV within DON exists from sexual contact with infected persons. Both the military and civilian courts are addressing the difficult issues that arise when personnel infected with HIV engage in sexual activity. The following briefly addresses military case law that has begun to accumulate and define behavior that is legally permissible and that which is successfully prosecuted.

One feature that distinguishes military cases is that the majority of cases have involved sexual conduct that was consensual, even though the sexual partner's consent was in most cases not based on knowledge of the defendant's positive HIV status, i.e., the partner agreed to have sex but was not aware the member was HIV-positive. Military courts have uniformly held that the consent of sexual partners to engage in sexual intercourse, even when they testified that they knew of their partner's condition, is <u>no defense</u> to a charge based on conduct causing a risk of transmitting the AIDS virus!

Service members who test HIV-positive are routinely counseled and receive and acknowledge written orders requiring them to tell prospective sexual partners about their HIV-positive status <u>and</u> to avoid specified unsafe sexual practices. In court-martial proceedings arising from the disobedience of these "safe-sex" orders, courts have consistently ruled that the orders had a <u>valid military purpose</u>, even when applied to

sexual conduct with civilians, and that the overriding need to stop the spread of AIDS, in the military and in society at large, justifies the orders' intrusion on the servicemen's privacy rights. The general rule is that a person cannot lawfully consent to have unprotected sex with an HIV-positive service member since this conduct causes or threatens bodily harm or death. Similarly, a person cannot "consent" to statutory rape nor have someone else harm them with a knife or gun. In one case an HIV-positive service member's conviction for aggravated assault after having unprotected sex with five females was upheld, even though there was no evidence of transmission of the virus. The court made the analogy of his having unprotected sex to threatening someone with a loaded gun. Even if his partners were not harmed, the potential to do harm was still present in these circumstances.

While the US military remains the only large group that involuntarily tests its members for HIV, test results are still treated as confidential. Even when the results are positive, very few people besides health care providers and commanding officers are informed of the results. Normally, any information obtained from a service member during or as a result of an epidemiological assessment interview may not be used against the service member in a court martial, nonjudicial punishment, involuntary separation for non-medical reasons, administrative or disciplinary reduction in grade, denial of promotion, unfavorable entry in a personnel record, bar to reenlistment, or any other personnel action considered to be adverse.

Military defendants have frequently argued that their positive HIV test results are protected as confidential medical information and should not be allowed as evidence in court proceedings. However, courts have decided that under certain specific instances statutes protecting the confidentiality of such information do not bar confidential AIDS or HIV information from being introduced in a criminal prosecution, e.g., when a defendant is charged with disobeying an order to practice safe sex or actually attempting to infect someone else with HIV. In one case the defense counsel objected to the admission of test results on the ground that the government had not established "chain of custody" for the blood samples taken from an Army private. However, the military judge admitted the medical record and test result, based on the reliability of procedures for maintaining medical records and ample evidence that the positive test results belonged to the private.

The military is unique in that sexual behavior of military personnel may be considered "conduct prejudicial to good order and discipline" under article 134 of the Uniform Code of Military Justice. First Amendment and related privacy concerns apply differently to the military community due to its unique mission and need for internal discipline. The courts have stated that military services and society at large have a compelling interest in ensuring that those who defend the nation remain healthy and capable of performing their duty. Indeed, other test cases have upheld vaccination and quarantine regulations and many states also have statutes making it a crime to expose others to sexually transmitted diseases.

Courts have ruled that a defendant's affliction with AIDS or HIV does not, by itself, warrant reduction of an otherwise appropriate sentence. Although the progression of

HIV disease may result in death, this medical condition does not preclude confinement in prison; nor is it likely to result in early parole. Indeed, several courts have decided that evidence of a sexual partner's exposure to a risk of infection by HIV is a proper basis on which to impose an enhanced or otherwise more severe term of punishment on the defendant.

Military cases have upheld the policies and restrictions placed on HIV-positive service members. In court cases, the ultimate responsibility for sexual behavior that places another person at risk for HIV infection has been placed squarely on the shoulders of the HIV-positive individual who has received medical counseling and an order from his or her commanding officer not to engage in specific risk behaviors (Appendix 2).

3. Personnel Policies Regarding HIV-Positive Personnel

a. Accessions

Both prior service and non-prior service applicants for active or reserve service will be screened for HIV prior to entrance on active duty or affiliation in the Naval or Marine Corps Reserve. Those who are confirmed HIV-positive are not eligible for naval service. All such personnel must have a negative HIV test within 12 months of accession. Testing will normally occur at the Military Entrance Processing Stations but may be conducted during other physical exams for accession.

Applicants for any commissioned or warrant officer procurement program are required to test negative within 12 months of being accepted into any such program and again prior to appointment as officers. An enlisted member in one of these programs that tests positive will be retained in enlisted status unless he/she requests discharge or is separated for disability. Students enrolled in ROTC who test positive will be disenrolled from the program at the end of the academic term. Naval Academy midshipmen will be separated from the Naval Academy and discharged at the end of the academic year when confirmed HIV-positive. In the final year, a midshipman who is otherwise qualified may be graduated without a commission and will be honorably discharged. Commissioned officers in professional education programs leading to appointments such as medical, dental, chaplain, or legal officers will also be disenrolled at the end of the academic term when they test positive. Personnel who were on active duty before entering these programs will be retained in a designator determined by the Chief of Naval Operations (CNO) or the Commandant of the Marine Corps (CMC) on a case-by-case basis, but reservists on inactive duty who were commissioned for the purpose of attending these courses will be discharged. Additional service obligation and financial assistance received during these programs will be waived; that is, the individual does <u>not</u> pay the military back in time or money.

<u>Accessions</u> who are confirmed positive are <u>not</u> sent for medical evaluation. They do receive counseling and support while awaiting separation. They also are not eligible for medical benefits after separation.

b. Reassignment

The commanding officer of any person who tests positive for HIV will initiate orders reassigning him/her to one of the three naval medical centers (San Diego, Portsmouth, or Bethesda) that conduct fitness for duty exams on HIV-positive personnel. Although the Navy Instruction does not mandate a specific time frame, generally personnel report to the medical center one to two weeks following notification of their positive results. The amount of time that service members require to arrange personal matters and outprocess will vary. Members returning to CONUS from overseas may need a longer period of time to arrange personal matters and the movement of personal property and family members. It is rare that personnel return to the same command to which they were assigned prior to testing positive. The Office of Manpower and Personnel, Military Compensation, Policy, and Coordinating Branch (MCPCB), is notified by BUMED of all positive test results and a designated Coordinating Officer in MCPCB serves as liaison to the HIV-infected member's detailer for his/her reassignment following the medical evaluation. However, this Coordinator has no rating specific billeting information or order writing capability. The detailer retains responsibility for the reassignment. As in other reassignments, the needs of the individual are considered and there is some flexibility regarding available billets.

Ratings are not changed when an individual is identified as HIV-positive, but the CNO or CMC may establish limitations on assignments or specific duties on a case-by-case basis. Personnel may be disqualified from a personnel reliability program (PRP); have their security clearance denied, suspended, or revoked; be suspended or terminated from access to classified information; or restricted from duties requiring a high degree of stability or alertness such as flight status, explosive ordinance disposal, or deep-sea diving.

Not only will HIV-positive personnel not be assigned to sea billets, but they will not be permitted to go TAD aboard Navy vessels, regardless of the destination or duration of the voyage.

Reserve component members testing positive for HIV are ineligible for active duty over 30 days unless mobilized. They may be retained in the Ready Reserve if billets are available that do not require immediate deployment or availability for reassignment overseas or to deployable billets. Otherwise, HIV-positive Reservists shall be transferred involuntarily to the Standby Reserve Inactive.

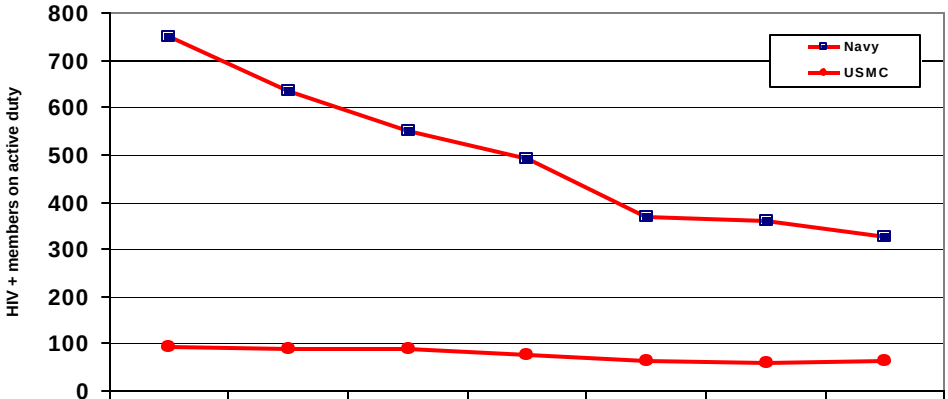
c. Retention on Active Duty

Military personnel who demonstrate no evidence of immunologic deficiency, neurologic involvement, or clinical indication of disease associated with HIV infection are retained in the Navy unless some other reason for separation exists or the service member elects to apply for separation. The Navy has invested time and money in training these personnel, who are capable of performing their duties without risk to themselves or others in normal work activities. At this time it is still difficult to determine whose infection will progress to AIDS and in what time frame, although currently persons with HIV infection are living longer and healthier than ever before.

A service member's HIV-positive status will not be used to deny reenlistment to members on continuous active duty. However, members who choose to separate on the basis of their HIV status will not be allowed re-entry into the service at any future date.

HIV Positive Sailors and Marines on Active Duty

Navy and USMC, as of the end of years 1993-1999 (all races, ranks, and genders)



	1993	1994	1995	1996	1997	1998	1999
Navy	751	634	551	492	368	360	322
USMC	91	88	86	76	62	57	63

Source: 1993-1998 data from Navy Central HIV Program, NNMC Bethesda; 3 May 99; 1999 (mid-2000) data from Navy Pers Com, 18 Jul 00.

Military members who test positive are assigned within the United States, which includes Hawaii, Alaska, and Puerto Rico. They may be assigned to units not normally programmed for deployment. The location will be within 300 miles of one of seventeen Naval Medical Treatment Facilities (MTF) that can provide medical care for them. The military members' units are responsible for funding all TADs to MTFs for evaluation and treatment.

d. Separation from Active Duty

On the basis of a fitness-for-duty medical evaluation, HIV-positive personnel are either returned to duty or referred to a Physical Evaluation Board (PEB) due to immunologic deficiency, neurologic involvement, or clinical indication of disease associated with HIV infection. The PEB has a medical officer as one of its members and generally follows the recommendations of the examining physician. If determined "unfit for duty," the member will be processed through the Disability Retirement System. A service member will be placed on the Temporary Disability Retirement List (TDRL) for five years before he/she is permanently retired. During this time, he/she periodically receives medical evaluations, usually about every eighteen months. As of the summer of 1999 there were approximately 1500 Navy personnel on TDRL due to HIV infection.

After testing positive for HIV, service members can request voluntary separation within 90 days after initial medical evaluation, beginning the day the medical board report of HIV-positivity is signed by the member. These personnel will be processed for separation for "convenience of the government" due to compelling personal need, a category not specifically designated for only HIV-positive members. The CNO or CMC have the option to deny the request for separation due to the needs of the military, but this has not occurred.

Commands processing individuals for voluntary separation will counsel each service member on his/her lost benefits resulting from voluntary separation. The individual's request for separation must document the absence of pressure or coercion to separate.

Members voluntarily separated from the active force by reason of HIV-positivity who have a remaining military obligation will be transferred to the Standby Reserve Inactive unless there are other medical reasons why the member would not be available to meet mobilization requirements.

Service members who are HIV-positive may be separated for other reasons, as a result of administrative or disciplinary proceedings. As discussed earlier, their HIV-positive status may be introduced in some situations, such as disregarding the preventive medicine order, but will not be used as the sole basis for separation.

4. Testing Requirements

Active duty personnel serving in overseas and deployable units and all active duty health care providers are required to be tested on an annual basis during each calendar year.

Commands may conduct HIV screening on a birth-month basis or in any other fashion they find practical.

Personnel issued Permanent Change of Station (PCS) orders to either a deployable continental US (CONUS) or overseas (OCONUS) command will have a negative test within 12 months of their transfer. All other personnel shall be tested in conjunction with routine medical exams if not already tested within the preceding 12 months.

Several groups have been identified for special consideration when testing for HIV. All military personnel identified with a sexually transmitted disease (STD), counseled or treated for alcohol or drug abuse, or presenting to a prenatal clinic will be tested. Beneficiaries who are not on active duty will be tested only with informed consent.

Reserve personnel who receive orders to active duty for 30 days or more, are subject to deployment on short notice, or who occupy select health care provider billets shall be tested on an annual basis. For other Reserve personnel testing will be conducted in conjunction with routine physical examinations or reenlistment exams.

5. Notification by Commanding Officers

When a military member tests positive for HIV, the testing laboratory notifies the service member's Commanding Officer as well as the HIV Central Office at BUMED. BUMED forwards information packets to commanders to guide them through the processing of the members until they report to a medical center for evaluation (appendix 2).

The notification instructions discuss the difficult task of informing a service member that he/she is infected with HIV. Some of the issues discussed include the following: An HIV-infected member should be notified in a timely manner to prevent further exposure of his/her sexual partners to the virus. Discretion is recommended when a lower ranking individual is called into the CO's office, so as to maintain confidentiality. The time and day when notification is made is important, so that support personnel such as an Independent Duty Corpsman (IDC) and chaplain are available. It is appropriate to be prepared for emotional reactions by a member to this very serious condition and to guard against the member contemplating suicide. It is appropriate not to leave the member with excessive free time. It is inappropriate to infer or presume a method of transmission of the HIV infection. A positive test does not automatically mean that a member is homosexual or an intravenous drug user. It is appropriate to reassure the member that he/she is not in immediate danger of dying, that there is still a career for him/her in the Navy, and that Navy medicine provides the best treatment available.

With the exception of supporting the member's emotional needs, commanders do not need to treat HIV-infected members differently than other members of the command. There is no risk to the health of the infected member, shipmates or coworkers in performing ordinary activities or in sharing heads, berthing spaces, galleys and workspaces.

The Commanding Officer can inform others of the member's HIV infection if he deems it necessary. For example, he may inform the IDC, physician, or chaplain, but preserving the confidentiality of the service member is mandated on a need-to-know basis.

The Preventive Medicine Order (PMO) is issued to HIV-infected members within approximately 30 days of arriving for duty at a new command following the medical evaluation. The PMO specifically prohibits the member from engaging in sexual activity or any activity in which bodily fluids may be exchanged with another person, mandates verbally advising any prospective sexual partner who consents to having sex of his/her HIV-positive status, prohibits consensual sex without the use of a condom, prohibits blood or tissue donation, and directs that he/she notifies medical and dental health care workers of his/her HIV-positive status prior to invasive procedures that may expose health care workers to his/her blood or other infectious body fluids. The PMO is signed by the member and witnessed by another officer. The original PMO is forwarded to BUPERS. The member and CO maintain certified copies until the member leaves the command.

6. Update of SECNAVINST 5300.30C TO 5300.30D

This Instruction is in the process of being revised. The annual requirement for 1 hour of HIV/AIDS preventive education is included in the new draft.

NEHC, with BUMED input, is tasked to provide information, education and behavior change programs to all Navy personnel and family members. Special emphasis will be placed on providing educational support to groups whose behavior may place them at higher risk of exposure to HIV. This includes STD patients and personnel seen in prenatal clinics, drug and alcohol programs, clinical laboratories and blood banks, and family planning clinics.

Unit 3: Medical Administration

1. Medical Testing Program

a. Frequency

The frequency of testing Navy personnel for HIV was discussed in Unit 2: Personnel Administration. To repeat, testing is required within the preceding 12 months of specific events or circumstances:

Entry on active duty
Applicants for commission or warrant
Serving overseas and in deployable units
All healthcare providers
Prior to OCONUS PCS
Selected Reserve personnel subject to deployment

An HIV test is also conducted as a part of all physical examinations unless a test was completed within the preceding 12 months. Since the frequency of physical exams has been lessened in the past few years due to the fact that young healthy military personnel do not have many medical problems and doing unnecessary exams wasted time and money, some personnel may not receive a physical exam for up to five years.

b. ViroMed Laboratories

The military has established a testing program and contract with one particular laboratory to ensure that blood samples are correctly labeled and accounted for, that notification of results is dependable, that analyzing techniques are standardized, and in short, that all possible measures are taken to correctly identify samples as positive or negative. Test results from other civilian laboratories or blood banks are unacceptable for documentation of a negative HIV test for military testing purposes.

All US Military Services use ViroMed Laboratories, a civilian laboratory in Minneapolis, Minnesota, that the military has contracted with to perform force surveillance testing of active duty personnel. Force surveillance testing is that testing which occurs routinely to screen the active duty force. Periodic testing helps ensure that the Navy's personnel in deployable billets are HIV-negative. Medical treatment facilities may also choose to process blood tests for HIV infection for other reasons, such as to screen women during pregnancy, to screen persons who contract a sexually transmitted disease, to provide pre-marital blood testing, or to screen personnel exposed to potentially contaminated blood. In either case, the processing time is very quick, typically less than a week to have results.

ViroMed has been certified by numerous agencies for operating in compliance with accepted practices for clinical laboratories and blood banks (College of American Pathologists, Clinical Laboratory Improvement Amendments, American Association of Blood Banks, Food and Drug Administration). Control mechanisms are in place to ensure that blood test specimens are correctly labeled and cannot be misidentified.

Shipping requirements that comply with Department of Transportation regulations ensure that specimens arrive at ViroMed in good condition and do not pose a risk of exposure to personnel working with the samples. Samples are shipped overnight to ViroMed via FedEx.

ViroMed reports negative results to the submitting agency. Very rarely, there are problems with a sample, such as breakage, where the submitting agency will have to redraw another blood sample.

All positive specimens are tested twice by the ELISA method and then confirmed by the Western Blot test. This process of confirming HIV-positivity by conducting the ELISA test twice, confirming the result with the Western Blot, and repeating the process with a second blood specimen is the standard protocol for all military testing.

c. Serodiagnostic Laboratory

The Serodiagnostic Laboratory (SDX) at NNMC reviews all contractor test results. The SDX reports all negative and positive confirmatory test results (Western Blot) to the submitting agency's HIV point of contact. In a population that has a low prevalence for HIV, such as the US military, most positive ELISA results for individuals without identified risk factors are false positives and are followed by negative Western Blot tests. False positive ELISA results may also occur because of the presence of other health problems such as blood malignancies, acute viral infections, certain antibodies present in the bloodstream which react to the ELISA test, autoimmune diseases, or alcoholic hepatitis.

False negative ELISA tests, i.e., personnel who test negative but are actually infected, may occur in the military population if the infection is recent and the development of antibodies to HIV has not yet occurred. This is quite possible in the military population, where personnel are frequently tested and when testing occurs shortly after exposure to the virus.

Military personnel frequently seek treatment within a few days of contracting a bacterial STD infection (if they experience symptoms). All STD evaluations include testing for HIV since personnel may have been infected with HIV at the same time as they became infected with the other STD. However, if personnel are examined within the first few weeks of co-infection with HIV, this would be too early to detect HIV antibodies. Therefore, military STD patients need to be retested for HIV seroconversion 3 to 6 months after diagnosis of any STD. Non-active duty patients will be tested for HIV with their informed consent (They can refuse HIV testing). DON policy for evaluation and treatment of STDs follows the 1998 CDC Guidelines for Treatment of Sexually Transmitted Diseases.

2. Medical Evaluation

All Navy personnel who test positive by the ELISA and Western Blot are sent TAD for 2-3 weeks to one of three Navy Medical Centers for a fitness-for-duty medical evaluation. Other Military Services may designate this evaluation as "HIV staging." In

either case, the examining medical officer is responsible for identifying health conditions that indicate that the disease process has advanced to the stage where the member is ineligible for continued military service.

a. Confirmatory Testing

A second blood specimen is drawn and tested for HIV during the fitness-for-duty evaluation. Conducting a second test serves as a fail-safe to preclude any doubt that a mistake could have been made in the earlier testing.

b. HIV Evaluation

The medical evaluation for HIV infection considers the medical history, physical exam, and laboratory studies. CD4 counts and viral load measures are documented during this evaluation and at periodic follow-up visits. Most HIV-positive military personnel are identified early in their HIV disease process through STD clinics or force surveillance testing. As a result, they tend to be followed long-term, which allows for establishing good continuity of care and appropriate adjustment of medications.

In the early days of AIDS, the pathology of the disease was not well understood, technologies were not available to assess viral activity and replication, and effective anti-retroviral medicines were limited. Military physicians used the Walter Reed Staging Classification (WRSC) system to place individuals in discrete groups along the disease continuum, based on a positive HIV antibody test, appearance of lymphadenopathy, progressive depletion of CD4 lymphocytes, appearance of skin test anergy, presence of oral thrush, and finally, opportunistic infections to indicate that HIV infection had progressed to AIDS. Personnel were retired when they reached the WRSC of 3 (CD4 count less than 400/mm^3) and were diagnosed with AIDS when they reached WRSC of 6 (opportunistic infection present). This created considerable anxiety among patients monitoring their CD4 count, when in fact their fitness for duty was not necessarily reflected by that parameter. During the 1990's scientists developed diagnostic testing that directly measured the amount of virus. Therapeutic treatment also improved, to the degree that the Walter Reed Staging System has became less meaningful to the PEB.

The CDC also has a staging system, revised in 1993, which is commonly used. Experts now agree that many social, political, and economic factors make it impractical to use rigid HIV classification systems throughout various populations. Staging systems remain useful as a tool to assess prognosis, define study groups, and determine the selection, timing, and appropriateness of treatments. The U.S. military now de-emphasizes rigid staging systems and focuses on symptoms, disease progression, and treatment. Medical evaluations are completed initially and at 6-month intervals for all active duty with HIV infection, although personnel are frequently seen more often for symptomatic treatment and adjustment of medications. The examining medical officer determines whether to return the military member to duty or refer him/her to the Central Physical Evaluation Board (PEB).

c. The Physical Evaluation Board

The PEB is a panel that includes a physician. The PEB usually follows the medical recommendation of the medical officer conducting the fitness-for-duty evaluation. If the service member disagrees with the PEB board's decision to separate him/her, there is an appeals process.

A military member found no longer fit for active service will be placed on the Temporary Disabled Retirement List (TDRL). Members on the TDRL will be reevaluated about every 18 months. After 5 years they are permanently retired. While on TDRL, they will receive a portion of their pay and certain tax exemptions, and are free to pursue civilian work. In the past HIV-infected personnel were not expected to improve clinically or be removed from the TDRL except to be permanently retired. However, a sailor on TDRL was reevaluated in 1999 and deemed medically fit for duty, i.e., his condition improved. He has since been brought back to active service. There has been no policy issued since then to distinguish between HIV and other disabling conditions, but if determined "fit for duty" upon reexamination, additional personnel may be brought back on active duty in the future. Declining to return to active duty would of course result in a loss of benefits.

d. HIV Counseling

During the initial HIV evaluation patients have the opportunity to ask questions concerning HIV infection in a supportive environment. Pastoral care and psychosocial counseling are made available. Patients are offered participation in HIV educational programs. They learn the mandatory nature of safer sexual practices and are informed that they must notify all health care providers (medical and dental) of their HIV seropositive status prior to receiving treatment. Other issues are discussed such as blood donations, pregnancy, and alternatives to sexual intercourse. They are also counseled on the importance of maintaining good health behaviors in general.

Counseling received from health care providers does not carry the legal weight of, or constitute, the Preventive Medical Order, which is provided by commanding officers. However, health care providers can still be directed to testify in court martial proceedings to establish that a patient was educated on his/her infectious status, the means of HIV transmission, and risk associated with sexual practices.

From the beginning of the program, the military leadership agreed on a clear division of responsibility between medical, administrative, and line responsibilities in dealing with HIV-positive personnel. The need to maintain a sense of trust and confidentiality between health care providers and patients was acknowledged. In a few instances, however, physical exams identified new STDs, clearly demonstrating that HIV-infected personnel had violated the Preventive Medical Order and some medical officers have felt obligated to report the behavior.

e. Medical Documentation

Many Military Treatment Facilities maintain the medical records of HIV-positive personnel outside the general medical records area, although there is no administrative guidance for this practice. Officially, the record is to be annotated “Blood Donor

Ineligible" which could refer to multiple infections, e.g., HIV, syphilis, hepatitis. In addition to this phrase, the Army uses an alphanumeric code to indicate HIV infection, while the Air Force simply writes "HIV" on the medical problem list inside the record. In any case, military records are controlled records. Information in the medical record is confidential and there is guidance on specific circumstances when such information can be released.

f. Medical Follow-up

Frequently, HIV patients are assigned to an internist who establishes a close relationship with his/her patients, facilitating easy access by the patients, and providing comprehensive care for the patients. That primary care provider may provide all care for the spouse as well.

Following the medical evaluation at one of the three Navy hospitals designated as HIV Evaluation and Treatment Units, personnel will be assigned close to one of 17 designated MTFs, where medical staff is available and qualified to monitor HIV-positive individuals and provide for their routine care.

Every six months the Administrative Division of the Navy HIV Program at NNMC informs commands by letter that members need to be reevaluated during the next calendar month at one of the three Navy hospitals. It is up to the command to call and set up the appointment and to cut TAD orders for the member. The commanding officer is responsible for not violating the member's confidentiality within the command. Although other personnel may notice these absences and suspect HIV infection, it is not difficult for the patient to justify periodic visits to an MTF by stating he/she has a chronic medical condition. Of course, he/she is under no obligation to do so.

Military service members are eligible to participate in clinical trials, which are scientific studies to examine differing protocols or medication regimens. Along with funding other research, the Henry M. Jackson Foundation for the Advancement of Military Medicine funds TAD for participation by HIV-positive personnel in HIV clinical trials. However, HIV-positive status does not provide service members with any special status or exemptions from duty. The degree to which conflict arises between the HIV-positive member and his/her command seems to be a function of overall duty performance of the member, flexibility of the command, and job-related duty requirements.

3. Epidemiology

During the initial medical evaluation at one of the three medical centers, preventive medicine personnel complete an epidemiological interview. This interview follows the same process as for other STD interviews. The interview is conducted to identify persons who may have transmitted the HIV infection to this patient as well as to identify persons to whom this patient may subsequently have transmitted the infection. The patient is given the opportunity to personally contact his/her sexual partners, or preventive medicine personnel can contact sexual partners who are active duty personnel or other military health care beneficiaries. Otherwise, preventive medicine personnel contact

appropriate public health offices or local national (overseas) public health authorities that make the notification to civilian sexual contacts. Military preventive medicine activities follow the State or host nation laws concerning reporting and contact notification. The preventive medicine interviewer maintains confidentiality of the military member. When sexual contacts of the patient are notified, the name of the patient is not provided to those persons. For example, "Petty Officer Smith, you have been named as a sexual contact to a person infected with HIV." At that point Petty Officer Smith is evaluated for HIV/STD; transmission of HIV may have occurred from the patient to Petty Officer Smith, from Petty Officer Smith to the HIV patient, or no transmission may have occurred between these two persons. If Petty Officer Smith tests HIV-positive, then the HIV evaluation process begins for Petty Officer Smith, to include an epidemiological investigation of his/her own sexual contacts. Since active duty personnel are routinely tested for HIV and IV drug use is minimal, tracing of contacts tends to be much easier than in the general civilian community. Preventive medicine technicians and other health care providers can identify the "window" in which the patient may have been communicable, based on prior testing, signs and symptoms, and reported sexual activity. Spouses of both active duty and reserve personnel will be notified and offered testing and counseling at no charge.

BUMED collects data on HIV for the Navy Department on the frequency of HIV infection, the characteristics of infected personnel, possible means of the HIV transmission, and trends. Data on Navy and Marine Corps personnel are reported to various DoD agencies. However, the data is reported in a manner to maintain the confidentiality of individual persons (see chart next page).

Navy Environmental Health Center, Directorate of Health Promotion and Medical Management, Sexual Health and Responsibility Program (SHARP)

Active Duty HIV Screening Data by Military Service, 1990-1999

USMC: active duty only [2, 3]		1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
	# Newly Identified HIV Positives	49	37	29	41	28	18	22	22	13	14
	# Tested	178,103	140,513	143,976	165,974	161,539	167,662	160,239	168,892	173,200	145,265
	Troop Strength (FY End)[1]	182,336	194,040	184,529	178,379	174,158	174,639	174,883	173,906	173,142	172,641
	rate pos/100,000 tested	28	26	20	25	17	11	14	13	8	10
	tests conducted/1000 members	977	724	780	930	928	960	916	971	1000	841
Navy: active duty only [2,3]		1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
	# Newly Identified HIV Positives	249	186	183	161	118	87	94	61	58	57
	# Tested	454,253	375,243	385,446	423,950	388,255	384,573	357,477	363,779	342,431	349,455
	Troop Strength (FY End)[1]	581,856	570,966	541,883	509,950	468,662	434,619	416,735	395,500	390,802	373,046
	rate pos/100,000 tested	55	50	47	38	30	23	26	17	17	16
	tests conducted/1000 members	781	657	711	831	828	885	858	920	876	937
Army: active duty only [4]		1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
	# Newly Identified HIV Positives	153	134	126	91	79	75	65	61	59	48
	# Tested	440,070	395,884	427,657	368,803	340,842	316,044	285,917	277,118	275,895	278,782
	Troop Strength (FY End)[1]	732,403	710,831	610,450	572,423	541,343	508,559	491,103	491,707	483,880	479,426
	rate pos/100,000 tested	35	34	29	25	23	24	23	22	21	17
	tests conducted/1000 members	601	557	701	644	630	621	582	564	570	581
USAF: active duty only [5]		1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
	# Newly Identified HIV Positives	65	56	47	39	27	33	35	27	31	21
	# Tested	228,720	140,089	181,252	155,572	142,578	126,353	103,847	122,303	156,127	183,350
	Troop Strength (FY End)[1]	535,233	510,432	470,315	444,351	426,327	400,409	389,001	370,297	359,856	360,590
	rate pos/100,000 tested	28	40	26	25	19	26	34	22	20	11
	tests conducted/1000 members	427	274	385	350	334	316	267	330	434	508

sources: 1. DoD Directorate For Information Operations and Reports (troop strength), www.web1.whs.osd.mil; 2. Naval Medical Surveillance Report, Vol 1 No 1, Jan-Mar 98, p12 (1990-1997 Navy and USMC data); 3. NNMC Bethesda data March 2000 (1998 and 1999 Navy and USMC data plus 1999 Army and USAF data); 4. (Army) Monthly Surveillance Medical Report Vol 5 No 5, Jun-Jul 99, p3; 5. USAF 311 Human Systems Wing, Force Protection, unpublished data, Oct 1999

Unit 4: Military Epidemiology

1. Effects of AIDS on the Military

HIV/AIDS affects, and will continue to affect, all segments of societies worldwide. Economic, political, social, and religious segments of numerous countries are facing significant challenges to business-as-usual practices. Previous methods of isolating and

treating communicable disease outbreaks are insufficient in dealing with this disease which is transmitted in intimate manners, has an extremely long incubation period, is not easily medically treated, and is not preventable by vaccine administration. The explosion in numbers of infections and deaths worldwide clearly illustrates that even geographical distance is not an effective barrier to HIV transmission.

Although the militaries of all countries have been affected by the HIV epidemic, those of developing nations are especially vulnerable to the effects of HIV. Ministries of defense in sub-Saharan Africa report averages of 20% to 40% HIV-positivity within their armed services, with rates of 50% to 60% in a few countries where the virus has been present for over 10 years.

In the long run these high percentages lead to attrition within the ranks and may result in loss of continuity of command at all levels. Commanders from some countries with high HIV prevalence worry about being able to field a full contingent for deployment on relatively short notice as the infection affects rising numbers of personnel. Even if new recruits can be found, readiness and smooth teamwork are compromised if people who have not served together previously fill absences. Preparedness is also hampered if highly skilled and experienced personnel are lost due to HIV disease. Since HIV disease tends to disproportionally affect young adults of military service age, costs have increased for the recruitment and training of replacements, to a greater or lesser extent within different countries. Within the US military the Department of the Navy has identified over 4500 active duty personnel infected with HIV, most of who have been medically retired. The US Navy spent approximately $40,000 to recruit and train each of these individuals, equating to $180M. The cost of replacing them would double that amount!

In countries with high HIV prevalence, military preparedness, internal stability, and external security could all suffer from continued personnel losses. Many countries utilize military forces in roles of internal police and disaster response, as well as national defense. Without stable militaries, regional destabilization and conflict are very real potentials. Future personnel losses in foreign militaries due to AIDS, to include leadership and policy makers, are a very real concern to the US.

A significant change has occurred in the way military forces are being trained and deployed around the globe. Regional conflicts, peacekeeping missions and multinational military cooperation have replaced the concept of nations preparing separately for the next major conflict in which allies cooperate but continue to conduct separate military operations. Therefore, multinational training between allied countries is extremely important to both the US and its allies. The US requires foreign military personnel provide a negative blood test before they begin training in the US.

A two-pronged approach to HIV in the military is to limit accessions infected with HIV and prevent new infections among personnel. The US military instituted bars to accession for HIV-infected applicants soon after an HIV antibody test became available in 1985 and provides ongoing education to its personnel. Some form of HIV testing is

conducted in many military forces around the world (93% of countries who responded to a 1995-96 survey). About 80% of military forces restrict accessions who are HIV-positive. About the same percentage restrict HIV-positive personnel from combat, overseas deployment, and piloting aircraft. However, some countries may not screen their military applicants for HIV, especially where the prevalence of infection is very high.

2. Risk Factors in the Military Population

According to the Joint United Nations Program on HIV/AIDS (UNAIDS), military personnel in general have a high risk of exposure to STDs, including HIV. That risk can increase dramatically during times of conflict. UNAIDS states that the single most important factor contributing to potential exposure to STD/HIV in the military may be the practice of posting personnel far from their accustomed communities and families for extended periods of time. In this new environment, personnel may be more prone to engage in high-risk sexual activities or alcohol/drug use. They may be temporarily free from social limitations on their behavior or scrutiny by their spouse, family, and other community members. "One-night-stands," multiple sex partners, sex with a new acquaintance, or sex for money all equate to the same thing, i.e., a greater likelihood of contact with contaminated body fluid that transmits HIV or transmits other STDs between sex partners.

Young, unattached persons are a highly susceptible group, both inside and outside the military. The young recruit on a weekend pass may have both the time and motivation, particularly under the influence of peer pressure, to indulge in high-risk behavior. However, personnel may not realize their true susceptibility to this disease, its severe consequences, or the likelihood of exposure. During liberty or similar "breaks" from either highly stressful or highly monotonous duty, personnel may practice binge behavior. Binge behavior with alcohol, sexual activity, or both can lead to high-risk exposures to HIV/STDs. Many military members engaging in high-risk sexual behavior are in their early twenties and may feel invincible. They may also have more money in their pockets than the local people, giving them the financial means to purchase sex. Military personnel, including the installations of peacekeeping forces, attract sex workers and those who deal in illicit drugs. The sex workers themselves may be IV drug users, making them likely candidates for transmitting HIV and other STDs to their military sex partners. One study in 1989-90 indicated that 10% of US Navy and Marine Corps personnel contracted a new STD during trips to South America, West Africa, and the Mediterranean. Following deployment, during which time personnel may have paid for sex from local sex industry workers, the potential exists for military personnel to spread HIV/STD infection to their spouses and CONUS sexual partners.

Women in the military, as elsewhere, are especially vulnerable. As well as being at higher risk of HIV because of the physiological means of transmission, they are often at a disadvantage when negotiating for safer sex, including the use of barrier protection. Without correct and consistent condom use, women are always more likely to acquire any kind of STD from a single sexual exposure than men. They also have more asymptomatic STDs that may go undetected even when they are highly contagious.

While true prevalence may be lower, in one study in 1998 almost 10% of female recruits were found to have chlamydia during a mass screening. One advantage for women in the US military is that they are required to seek routine gynecological care, during which they may be screened for STD.

3. Global Distribution and Subtype

US military commanders are naturally concerned about the presence of any diseases in countries in which their forces deploy or train. Potentially, the US Navy could send personnel to virtually any geographical region worldwide. It is important to identify risk from HIV and other infectious diseases, based on scientific evidence, and to design strategies to prevent that exposure. In fact, historically military forces have been among the most traveled of any groups and have been instrumental in the spread of disease between countries.

HIV has rapidly spread throughout the world. No country has been spared, regardless of its political, religious, or social differences. By the year 2000 there may be as many as 40 million persons infected with HIV. However, genetic analysis of strains collected around the world has shown distinct differences in the virus. There are at least ten distinct genotypes, or clades, of HIV which are distinguished through molecular genetics. When looking at a global map, clear geographical patterns of distribution of these clades emerge. To repeat basic virology of HIV, evolution of the virus occurs by point mutations on the RNA strands as well as during recombination of two RNA strands during reverse transcription. All RNA viruses, including HIV, that lack enzymes needed for replication are prone to error when they reproduce. Within all the major clades, there now exist as many as 10^{17} genetically unique strain variations. These facts help explain the difficulty of producing an effective vaccine or long-term effective medication regimens.

Clades are commonly referred to by letter designations, A through J and another distinct subtype called O, indicating the order in which they were identified. Although 50% of all strains reported belong to clade B, the high proportion of B may be merely a reporting error due to underreporting of other strains by less developed countries. Clade B is found predominantly in the US, Europe, and South America. The oldest known HIV strain, Z321, is clade A, isolated from stored serum obtained in Zaire in 1976.

Different clades may be more easily transmitted by certain behaviors. For example, in Thailand 95% of heterosexually acquired cases are clade E, while most IV drug users (80%) suffer from clade B. Thailand is experiencing two simultaneous epidemics, a slower one caused by clade B and a rampant, heterosexually transmitted one caused by clade E. The risk of infection to a male sex partner from a female infected with clade E virus is also 10-fold higher than it is in the US by the clade B. By the end of this decade, clades E and C will probably account for more infections than all other clades, while clade B is expected to plateau worldwide. This has definite implications to US Navy personnel who will undoubtedly continue to travel throughout the world.

Another type of retrovirus that can cause AIDS is HIV-2, distinct in its DNA sequences, from HIV-1, the cause of most AIDS cases in the US. This virus is found predominantly in West Africa but has not caused nearly as many cases of disease as HIV-1. One scientist estimates that HIV-1 diverged from HIV-2 around 1950 and continued to evolve into the other HIV-1 clades over the past half century. Other scientists place the origin of the HIV-1 virus back hundreds of years. There is also some support in the scientific community that human HIV evolved from an animal virus.

In the US epidemic, one person is thought to have "seeded" the virus throughout North America. This person is referred to as "patient zero," but he could have only been responsible for the epidemic of the B clade. Globally, there would have to have been at least ten patient zeros, one for each distinct clade of HIV-1.

As part of the ongoing study of the distribution of HIV-1 subtypes and the risk factors associated with each, NMC San Diego is examining a group of HIV-positive personnel. All subjects with non-B subtypes report only heterosexual contact; all 6 subjects with subtype E had a history of sexual contact outside the U.S. during the time they seroconverted. It has also been demonstrated that personnel can be infected with one or more clades at the same time or be co-infected with both HIV-1 and HIV-2. This preliminary study and the continuing clade study of HIV-1 worldwide demonstrate that the global epidemic may not be as easy to contain as previously thought. HIV, with its high rate of replication error, may continue to adapt itself to its human hosts. These changing genotypes may become more deadly, more easily transmitted, and less easily treated. It remains imperative that US Navy and Marine Corps personnel not unknowingly facilitate the continued spread and mutation of these various strains of HIV.

4. Military Educational Programs

Although military personnel as a group are at high risk for exposure to HIV, in some ways US military organizations have a greater capability to implement effective HIV/AIDS prevention programs than the civilian sector. All US military services were directed to implement mandatory HIV educational programs early in the epidemic and provide annual education to inform and motivate personnel to adopt less risky behaviors. Military commanders have the authority to direct actions and implement institutional changes quickly and without dissention from within the ranks. There is also a strong tradition of senior enlisted and officers taking actions which provide for the welfare of their personnel. As a highly structured organization, already focused on continuous training, the military was in a good position to implement HIV education within their training cycle. In addition, the military population is a captive audience, so that general HIV education can be provided to virtually all assigned personnel.

These characteristics are very positive attributes of the military in combating the spread of HIV/AIDS. Just as they would deal with any other factors that decreased readiness, commanders must ensure that personnel have the knowledge, skills, and motivation to make appropriate sexual decisions.

The Navy continues to require a minimum of one hour training on HIV/AIDS to active duty personnel. The training is completed in a variety of forums, e.g.,

*unit training/SEMPER FIT
*recruit training
*Marine security guard training
*Marine shipboard training
*"Prevent 2000" training for junior enlisted grades

Military health care professionals provide individualized counseling to identified high-risk groups and HIV-positive personnel receive ongoing counseling and support to avoid further transmission of the virus to others.

Appendix 1
Recommended Immunizations
For HIV+ Adults and Adolescents

Recommended Immunizations for HIV+ Adults and Adolescents

PURPOSE: Both pneumococcal and influenza vaccine are thought to be helpful in adults with HIV infections. For adults who have not completed routine childhood immunization schedules, guidance is listed in the table below. Hepatitis B vaccine should be considered for all sexually active adults who do not have serologic evidence of prior exposure. The efficacy of vaccines in preventing these infections in HIV/AIDS patients has not been proven.

Recommended Immunizations for HIV+ Adults and Adolescents

Vaccine Type	Asymptomatic HIV Disease	Symptomatic HIV Disease
Pneumococcal	yes (single dose)	yes (single dose)
Influenza	yes (yearly)	yes (yearly)
Tetanus booster	yes, if indicated (q 10 yrs)	yes, if indicated
Hepatitis B*	yes, if seronegative	yes, if seronegative
Hemophilus influenza Type B	yes (single dose)	yes (single dose)
Measles	yes, (if otherwise indicated)	yes, (if otherwise indicated)**

*Some patients may require additional booster vaccine for Hepatitis B to obtain adequate titers

**Unless severely immunocompromised. Death has been reported due to vaccine-acquired measles

Recommended Immunization for HIV+ Children (may be indicated in adults or other family exposed to young children)

Vaccine Type	Asymptomatic HIV Disease	Symptomatic HIV Disease
DTP	yes	yes
OPV	**NO**	**NO**
IPV	yes	yes
MMR	yes	consider
HiB	yes	yes

Recommended Immunizations for HIV+ Patients Traveling to Developing Countries (as adapted from *AIDS Clinical Care*):

- Immune globulin (omit if patient has serologic evidence of Hepatitis A)
- Measles or MMR (omit if patient has evidence of immunity)
- Typhoid, inactivated parenteral
- Polio, enhanced inactivated
- Destination-dependent: Cholera, meningococcus, plague, rabies, yellow fever.

All patients traveling to other countries should be evaluated for required immunizations and prophylaxis based on their destinations. CDC's travel hotline number is (404) 332-4559. See also Prevention of Exposure to Opportunistic Pathogens protocol.

Reference:

1. CDC. Recommendations of the Immunization Practices Committee. *MMWR* 1993; 42[No. RR-4].
2. Hecht, F.M., Soloway, B. *HIV Infection: A Primary Care Approach*, Revised Edition. Waltham: Massachusetts Medical Society. 1993;39-40.
3. Wilson, M. Traveling with HIV. *AIDS Clinical Care*. 1991;3:49-51.
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Appendix 2

Guide for Commanding Officers and Officers In Charge of HIV Infected Members

GUIDE FOR COMMANDING OFFICERS AND OFFICERS IN CHARGE OF HIV INFECTED MEMBERS

TABLE OF CONTENTS

NOTIFICATION

One of the most difficult things a Commanding Officer may ever have to do is tell one of his/her assigned personnel that he or she is infected with HIV, the virus that causes AIDS. **Appendix A is a sample HIV notification letter that arrives marked SENSITIVE - FOR CO's ONLY.** It is not feasible to design an all-purpose counseling statement for such an occasion. However, the following facts and ideas may be helpful when informing one of your Sailors that he/she is HIV infected:

- HIV diagnosed members must be notified in a timely manner to prevent further infection of others. A positive test only means that a member has been infected with HIV. It does not mean that he/she has AIDS. Because the Navy frequently tests its members, those who are HIV diagnosed are most often in the early asymptomatic stages of infection.

- Exercise discretion when calling the HIV+ member to your office for notification.

- When possible, notification should be done early in the week and after hours. Try to avoid telling the member on a Friday or the day before the member's leave or liberty period when the member may have inadequate emotional support.

- A physician/Independent Duty Corpsman (IDC) and chaplain should be immediately available to the member after notification, but avoid having them in your office at time of notification - as their presence only adds additional alarm.

- It is inappropriate to infer or presume a method of transmission of HIV infection. A positive test does not automatically mean that a member is homosexual or an intravenous drug abuser. ***HIV infection is possible regardless of sex, race, ethnic group or sexual orientation***. For all practical purposes, HIV infection is a sexually transmitted disease occurring from contact with blood, semen, vaginal fluid and sometimes breastmilk.

- Most members who test positive are completely unaware that they are infected with HIV. However, occasionally the member already knows or suspects he/she is infected (e.g., member donated blood and was informed by the American Red Cross, was concerned and tested through a civilian source, or engaged in a risk relevant behavior and became concerned).

- Reassure the member that he/she is not in immediate danger of dying and there is still a career for him/her in the Navy. Additionally, Navy Medicine is on the cutting edge in treating HIV infection.

- Initial counseling about HIV infection is often not totally comprehended. Offer to make yourself or another person (i.e., XO, CMC) in the command available for questions that may follow after initial notification.

- **A REQUIRED MESSAGE INDICATING THAT THE INDIVIDUAL HAS BEEN NOTIFIED MUST BE RETURNED TO DCNO(M&P)(N130H) WITHIN 10 WORKING DAYS.** *See appendix B for sample message format.*

- An HIV+ member should not be treated any differently than any other members of your command. *There is no risk to the health of the infected member, shipmates, or co-workers in performing ordinary activities* such as sharing heads, berthing spaces, galleys and workspaces. The virus is not spread by casual contact such as sneezing, shaking hands, sharing eating utensils, sweating, etc.

FREQUENTLY ASKED QUESTIONS

What will happen to my career?

The member has 90 days after the initial evaluation to decide whether to remain in the Navy. Members can apply for separation due to HIV status within 90 days after initial evaluation & classification. The 90-day period begins the day the medical board report is signed by the member. Separation after the 90-day period has expired will be considered on a case-by-case basis. Separation can be delayed up to 180 days after evaluation. Members who volunteer for separation will be processed for *convenience of the government due to compelling personal need*. Members who elect separation will not be allowed re-entry into the service. Reasons CNO/CMC may deny requests for separation and additional separation guidelines are documented in SECNAVINST 5300.30C.

HIV+ members may no longer be permanently assigned OCONUS, to sea duty or routinely-deployed units. Junior enlisted members in sea intensive ratings (i.e., OS, BT, QM, etc.) may have to change their rating to have a viable career. HIV+ pilots, NFOs and aircrewmen are permanently grounded and reassigned to shore duty.

Can I advance?

Yes. By law, personnel records cannot contain a member's HIV status nor can a member be denied reenlistment or promotion solely because of HIV infection. Outstanding performance is the key, since HIV+ members are subject to high year tenure, ENCORE, Continuation Boards and Selected Early Retirement Boards (SERB).

Will I have to inform my spouse/significant other that I am HIV+?

It is your moral responsibility to personally notify people you may have infected. When you get to the hospital, you will be asked to list all of the people you may have infected. All active duty members will be officially notified by the military, and civilians will be officially notified by the state in which they reside. Navy Preventive Medicine personnel are authorized to notify active duty spouses.

*** Commanding Officers. Due to various state laws, you nor other members of your command are legally authorized to notify assumed prior/potential sexual partners of their contact with an HIV+ member.*

Who in the command knows I'm HIV+?

Right now, just myself, Chaplain _____ and Dr. _____ (or an Independent Duty Corpsman when no physician is available). With your permission, I would like to inform _____, so that he/she may help you prepare for MEDEVAC/transfer from the command, and be available to answer any questions you may have after our meeting today.

One of the most important issues to an HIV+ servicemember is his/her knowledge that only a very select few are aware of their being infected with HIV. It goes without saying that the CO must be extremely vigilant to ensure the member's confidentiality is not compromised. If you inform someone else in your command, you should advise the servicemember of your decision.

MEDICAL EVALUATIONS

DoD Directive 6485.1 provides a detailed outline of clinical requirements for periodic medical evaluations of HIV diagnosed members.

INITIAL EVALUATION

A two-week evaluation is conducted at National Naval Medical Center (NNMC) Bethesda, Naval Medical Center Portsmouth, or Naval Medical Center San Diego.

- Do not rush the member to the medical facility immediately after notification that he/she is HIV+. Rapid removal from the command can be very stressful for the member and puts additional disruption, confusion and sense of loss on top of the initial bad news. However, remaining at the command can also be stressful if confidentiality has not been maintained. 10-14 days is usually sufficient time to arrange personal matters. Members returning to CONUS from overseas may need a longer period to arrange and supervise movement of household goods and family members.

- **TRAVEL INFO**. Members traveling from OCONUS or a ship should be transferred/TEMDU to one of the three Navy medical treatment facilities (MTF) noted above. A member returning to a Type 1 (CONUS) after initial evaluation may transferred/TAD to the MTF. The following line of accounting is provided for transfer of Navy/Marine inpatients worldwide and their non-medical attendants outside CONUS:

- **Line of accounting data for TEMDU orders**:
  SDN: N0001890MD00CMF
  DE 9700130 188M 210 00018 M 068688 2D MEE000 0018099013E
  - Numbers underlined above represent the fiscal year.
  - This accounting data also covers one non-medical attendant (e.g., spouse). Travel funds for additional non-medical attendants are a parent command responsibility.

- An agent should be designated (in writing) to care for and store household goods until shipment to next duty station can be arranged.

- Initial evaluation includes:
  - HIV+ confirmation, complete physical, psychological counseling, drug/alcohol training and legal counseling.

- Determination of fitness for duty. Most members are found fit for full duty. They are assigned/reassigned to Type 1, CONUS shore duty (to include P.R., Alaska, and Hawaii) within 300 miles of an MTF.

- Members not fit for full duty are transferred to the Temporary Duty Retired List (TDRL) or Permanent Duty Retired List (PDRL). The Physical Evaluation Board (PEB) determines percent disability.

FOLLOW-UP EVALUATIONS

A complete medical evaluation and follow-on HIV/AIDS counseling and education is required at 6-month intervals.

- Last 1-2 weeks.
    - Provided at the 3 major Navy MTFs previously listed.
- TAD funding is provided by the member's command. Though the command has no funding obligation, it is strongly encouraged to authorize travel for the spouse of an HIV+ member to attend the evaluations.

EXPERIMENTAL PROGRAMS

Many HIV+ members have volunteered for experimental treatment protocols conducted either NMC San Diego, Walter Reed Army Medical Center (WRAMC) Washington, D.C. or NNMC Bethesda. HIV+ members participating in experimental treatment protocols may require short (1-2 day) monthly evaluations. Funding of protocols, TAD funding and travel arrangements for enrolled members are provided by the Henry M. Jackson Foundation, Bethesda, MD.

PREVENTIVE MEDICINE ORDERS

Within 30 days of a known HIV+ member arriving PCS to your command, a Preventive Medicine Order (PMO) will arrive from N130H marked SENSITIVE - FOR COs EYES ONLY. *(See appendix C for example.)*

The PMO is a legal order that the member must obey and is not to be confused with the counseling statement the member may have signed during initial or follow-on treatment. The hospital counseling statement is *not* an order but a physician's advisory informing the member of the potential for transmission of the HIV infection.

- The CO is responsible for ensuring that the PMO is signed by the member with a witnessing officer present. The witnessing officer should be someone other than the CO so that in the event of a PMO violation, the CO can provide Captain's Mast.

- **Return original PMO to OPNAV (N130H)**. Provide a copy to the member and retain a copy in the CO/XO safe until the member is transferred from your command. Destroy PMO during member's PCS departure from command.

- If you receive a PMO for a member not assigned to your command, simply write across the top of it NOT ASSIGNED TO THIS COMMAND and return it to N130H. *Do not attempt to forward a PMO.*

EDUCATION AND TRAINING INFORMATION

SECNAVNOTE 5300 requires that all commands conduct a minimum of 1-hour HIV/AIDS prevention education each year with emphasis on modes of transmission and methods of prevention. Initial training must be documented as a (Page 13) Service Record entry.

DON civilian employees and their supervisors (military and civilian) should receive information relevant to HIV/AIDS and workplace policies, procedures, and resources. Classroom training may be employed but is not necessary.

Resources to assist you with training materials are available from local MTFs, Navy chaplains, American Red Cross, local community institutions, and the AIDS Clearinghouse, PO Box 6003, Rockville, MD 20850. Additional resources may be obtained by contacting:

a. BUMED HIV Education Office (MED-02H): DSN 295-0048 or COMM (301)295-0048.

b. Chief of Naval Education and Training: DSN 922-4027 or COMM (904) 452-4027.

c. Headquarters Marine Corps: DSN 426-1174/1175 or COMM (703)696-1174/1175.

d. Commander, Naval Reserve Force (CNRF-009): DSN 698-5422 or COMM (504)678-5422.

6220
Ser 02H/(1173B1)

From: Chief, Bureau of Medicine and Surgery
To:

Subj: HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODY POSITIVE RESULTS

Encl: (1) Guide for Commanding Officers and Officers in Charge Of HIV Infected Members
(2) Confirmatory Positive Test Report

1. The following individual in your command has tested positive for the HIV antibody.

SSN	DOB YR/MO/YR	LAST NAME

2. Process the above individual per enclosure (1) and transfer individual to the nearest Navy medical treatment facility for evacuation to **[facility name]** for medical evaluation. Point of contact at **[facility name]** is **[POC name and phone number]**.

3. An example of the required message confirmation indicating that the above individual has been notified is contained in enclosure (1), appendix b. Please forward this message to the Deputy, Chief of Naval Operations (Manpower and Personnel)(N130H) within 10 working days of receipt via message, mail or fax (703)614-9474. N130H can not discuss follow-on assignments, a replacement for this member or any other related issues with the individual until this confirmation message is received. If the member has PCS orders to a Type 2 or above (sea or overseas) duty station, inform him/her that the orders will be cancelled. Enclosure (2) is for the member's medical and dental records.

4. My point of contact is HM1 D. Nichols, USN (MED-02H) at (301) 295-6590 or DSN 295-6590.

W. TAUBER
By direction

Copy to:
NNMC Bethesda (HIV Evaluation Unit)
DCNO(M&P) (N130H)

APPENDIX A

ADMINISTRATIVE MESSAGE

ROUTINE

R 140001Z _____ ZYB
(actual command notification date)

FM _____
(notifying command)

TO CNO WASHINGTON DC//N130H//

UNCLAS //N06220//

MSGID/GENADMIN/_____
(notifying command)

SUBJ/CONFIRMATION OF NOTIFICATION

REF/A/DOC/BUMED/_____
(date of notification ltr)

AMPN/REF A IS BUMED NOTIFICATION LTR 6220 SER 02H/_____
(exact serial number of BUMED ltr)

RMKS/1. IAW REF A, SNM NOTIFIED THIS DATE.//

APPENDIX B

1300
Ser N130G1/H5818
02 Jun 2000

SENSITIVE - FOR OFFICIAL USE ONLY

From: Medical Program Manager (N130G1)
To: Commander, NAVRESREDCOM REG SIX, 1014 "N" St., S.E., STE 310,
Washington Navy Yard, Washington, DC 20374

Subj: PERSONNEL ASSIGNMENT

Ref: (a) SECNAVINST 5300.30C
(b) OPNAVINST 1160.5C

Encl: (1) Preventive Medicine Order (PMO)

1. The Navy tests its members for Human Immunodeficiency Virus (HIV) which is associated with Acquired Immune Deficiency Syndrome (AIDS). Reference (a) provides guidance and background on the Navy's HIV testing program and management of HIV infected personnel. This letter advises you that YNC John David Smith, USN, 123-45-6789 is assigned to your command, and has tested positive for the HIV-antibody. He has completed medical evaluation and has been determined by competent medical authorities to be fit for duty. During the course of his evaluation, he has been counseled regarding the modes of transmission, precautions, and personal hygiene measures to minimize transmission of the virus, and requirements established to notify past and future sexual partners. Although he has tested positive for the HIV antibody, he is not ill and not contagious except through blood or bodily fluid exchange. He is fully capable of working at any task consistent with his paygrade and skill level. Some HIV positive members require periodic time away from the command for medical care and counseling. Should these absences become an unreasonable burden to your command, contact my HIV Program Manager for resolution at DSN: 225-2974 or COMM: (703)695-2974.

2. In accordance with reference (a), the following guidelines must be strictly adhered to when managing HIV infected workers:

a. An HIV member's status must be treated with the highest degree of confidentiality and released to no one without a demonstrated need to know. Key personnel within your activity who, in your judgment, have a demonstrated need to know in order to perform a job must be advised that the release of the member's medical status to others is strictly prohibited and could result in disciplinary action.

b. The Secretary of the Navy has approved the issuance of Preventive Medicine Orders (PMO) to HIV infected personnel. The PMO: safeguards the health, welfare, safety and reputation of commands; ensures readiness and the ability of the command to accomplish its mission; and prevents the spread of HIV/AIDS. A commissioned officer, designated by you, should issue the PMO (enclosure (1)) to the member. Sign, date, and return the original (double sealed) to the Deputy Chief of Naval Operations (N130G1), Department of the Navy, Arlington Annex, Washington DC 20370-5000. Two duplicates of the completed transmittal, certified as true copies, should be retained. Keep one for your files and give one to the servicemember.

c. Ensure member and his family is provided an opportunity for medical, social, and pastoral counseling. Family Service Center personnel are trained to assist you in this task. The HIV infected member should consent to such counseling or assistance.

d. Prohibit the member from donating blood to ensure protection of the blood supply, and require a needle injection vice air injection gun when given vaccines.

e. Reenlistments and enlistment extensions for HIV positive personnel are subject to Navy-wide reenlistment programs. There are no restrictions on reenlisting or extending personnel solely because they are HIV positive. They must be found medically eligible for reenlistment based on a military physical examination, and meet the requirements of reference (b) as appropriate.

f. Navy policy pertaining to allowing HIV positive members to perform Temporary Additional Duty (TAD) in the continental United States (CONUS), Sea/Shore Code 1 duty only, is the decision of the Commanding Officer. Use your own discretion when determining if the receiving Commanding Officer should be informed of the member's medical condition. However, the receiving Commanding Officer should be notified if the TAD assignment is greater than 30 days.

g. If the member is reassigned to another activity for any reason, **DESTROY THIS LETTER**. Do not forward notification to the gaining command.
The Special Assistant for HIV policy (N130G1) will initiate the proper notification.

h. If the servicemember leaves the service at EAOS, an RE-4 reenlistment code MUST be assigned.

i. The member will be required to have a semiannual medical evaluation. You will be notified by official letter by the Bureau of Medicine and Surgery (BUMED) when and where the member is to report for this evaluation.

3. Education is vital to the success of reducing the risk of acquiring, or transmitting, HIV. The Navy's Sexual Health and Responsibility Program (SHARP) offers education assistance available through http://www-nehc.med.navy.mil/hp/sharp or by calling DSN: 253-5566 or COMM: (757) 462-5566.

4. For further assistance for HIV policy and assignments, please contact me at DSN: 225-2974 or COMM: (703)695-2974 or PN2(SW) D. Brewer at DSN: 224-5562 or COMM: (703) 614-5562.

J. R. BECKHAM

Enclosure (1)

PREVENTIVE MEDICINE ORDERS FOR HIV POSITIVE PERSONNEL

This command has been advised that you were counseled by Preventive Medicine personnel concerning your HIV positive diagnosis, the risk this condition poses to your health, as well as the risk you pose to others. During counseling, you were advised by medical personnel as to necessary precautions you should take to minimize the health risk to others as a result of your condition. This command has great concern for the health, welfare and morale of you and others in this command. For these reasons, I am imposing the following restrictions on your conduct described to you in your medical counseling:

1. Prior to engaging in sexual activity, or any activity in which your bodily fluids may be transmitted to another person, you must verbally advise any prospective sexual partner that you are HIV positive and the risk of possible infection.

2. If your partner consents to sexual relations, you shall not engage in sexual activities without the use of a condom.

3. You must advise your potential partner that the use of a condom **does not** guarantee that the virus will not be transmitted.

4. You shall not donate blood, sperm, body tissue, organs or other body fluids.

5. You shall refrain from any injection using an air gun.

6. In the event that you require emergency care, you are ordered to inform personnel responding to your emergency that you are HIV positive, conditions permitting (e.g., unconscious).

7. When you seek medical or dental care, you must inform health care providers that you are HIV positive before treatment is initiated.

IMPORTANT: Your failure to comply with these orders may subject you to disciplinary action under the UCMJ and/or administrative separation.

I acknowledge understanding of the above orders.

_____ _____
Member's signature Date
YNC John David Smith, USN, 123-45-6789

Orders transmitted and member's signature witnessed by:

Signature:_____
_____
Printed Rank, Name, SSN and Date

Distribution:
Original to: DCNO (M&P) (N130G1), Dept of the Navy, Arlington Annex, Washington DC 20370-5000
Certified Copy to: Member and Commanding Officer's file

APPENDIX C

Thanks for completing this course.

You may provide your exam answers to SHARP by completing the
on-line answer sheet at the SHARP internet site (the preferred method)
or
answers may be mailed, faxed, or e-mailed to SHARP.

On-line answer sheet: http://www-nehc.med.navy.mil/informatics/websharp.htm
e-mail: macdonaldb@nehc.med.navy.mil
voice: (757) 462-5566; DSN 253-5566
fax: (757) 444-1345; DSN 564-1345
mail:

Navy Environmental Health Center
ATTN: HP/SHARP
2510 Walmer Ave
Norfolk VA 23513-2617

Navy HIV Course Exam

True or False. Mark either T or F.

1. The SHARP program seeks to promote military readiness by reducing HIV and STD infections. T F

2. Military personnel with HIV infection no longer receive any vaccinations. T F

3. Military personnel can only be court-martialed if HIV is transmitted to their sex partner. T F

4. HIV-positive status will not be used by the Navy as the sole basis for initiating any adverse personnel action against a service member. T F

5. Military personnel cannot refuse HIV testing. T F

6. Personnel who test positive for HIV may not come on active duty, but may join the Reserves. T F

7. New accessions to the Navy who test positive for HIV are sent to one of three Navy medical centers for medical evaluation. T F

8. The Coordinating Officer at BUPERS tells the detailer of an HIV-positive service member where to assign the member. T F

9. ViroMed Laboratories has to meet civilian blood testing standards even though it has a contract with the government. T F

10. A negative HIV test completed by the American Red Cross during a local blood drive can be used by Navy personnel to document HIV status. T F

11. Medical treatment facilities are responsible for maintaining the confidentiality of medical record information. T F

12. HIV-positive personnel are restricted from participating in civilian medical studies as long as they remain on active duty. T F

13. Military personnel exposed to HIV through sexual contact or blood donation are entitled to know the name of the source of HIV. T F

14. The US has the only military that conducts HIV screening of its personnel. T F

15. Military personnel as a group possess many high-risk characteristics for exposure to HIV and STDs. T F

16. Women are at greater risk than men of contracting HIV infection from sexual intercourse. T F

17. Navy personnel may be exposed to different strains of HIV as they deploy worldwide. T F

18. The origin of HIV that causes AIDS in humans has been definitely identified. T F

19. All Navy personnel are required to receive at least one hour of education annually on HIV. T F

20. Commanding Officers may not grant permission for HIV-positive sailors to remain in deployed billets aboard ship. T F

21. Navy civilians can be ordered to have an HIV blood test if they deploy overseas. T F

Multiple Choice. Mark the best answer for each statement.

22. HIV-positive personnel may be retained on active duty:
a. for up to a maximum of 10 years following infection.
b. when they progress to AIDS if they are assigned light duty.
c. unless they take medication to fight the disease process.
d. until the are determined to be unfit for duty.

23. Which of the following statements is FALSE?
a. Personnel infected with HIV are not deployed because of potential exposure to disease.
b. Standard living conditions aboard Navy vessels do not cause HIV transmission.
c. The military blood supply is not screened for HIV because they do not accept civilian donors.
d. Navy medical personnel follow "Universal Precautions."

24. An HIV-positive member can legally engage in sexual intercourse if he/she
a. first informs his/her sex partner of his/her HIV status.
b. uses a condom.
c. both a. and b.
d. doesn't infect his/her partner.

25. The Preventive Medicine Order
a. restricts the sexual conduct of military members but not family members infected with HIV.
b. is enforceable under UCMJ.
c. directs the HIV-positive member to communicate his/her status with health care workers before care is rendered.
d. All of the above

26. Which of the following statements is FALSE?
A service member will be separated from active duty if he/she
a. is identified HIV-positive at time of reenlistment.
b. is deemed unfit for duty by a medical authority and PEB.
c. requests separation within 90 days of initial HIV evaluation.
d. has failed to meet other retention standards.

27. An HIV-positive member can be assigned to all locations EXCEPT
a. Puerto Rico.
b. Guam.
c. Alaska.
d. San Diego.

28. Personnel found to be HIV-positive
a. will be automatically retired for medical reasons.
b. will be able to request separation at any time in the future.
c. may request a type of separation that is reserved for only HIV-positive personnel.
d. will be placed on the Temporary Disabled Retirement List if found to be unfit for duty.

29. After informing a service member that he/she is HIV-positive, it would be appropriate for the commanding officer to
a. reassign that member to "special duty" projects pending TAD for medical evaluation.
b. restrict all his/her food-handling duties.
c. determine his/her emotional state.
d. reassure his/her shipmates that he presents no risk to them from casual contact.

30. The Preventive Medicine Order is issued by
a. the examining medical officer.
b. the commanding officer who notifies the member of his/her positive test.
c. the commanding officer of a unit to which a member is assigned following medical evaluation.
d. a member's sexual partner.

31. A service member is <u>medically retired</u> if he/she
a. has a neurologic impairment due to HIV infection.
b. tests positive for HIV, confirmed by a Western Blot test.
c. requests medical retirement based on his/her positive HIV test.
d. is found guilty of sexual assault on the basis of his/her HIV status.

32. Navy physicians routinely see HIV-positive personnel
a. for signs or symptoms of illness associated with the disease process.
b. for side effects to the HIV medications.
c. every 6 months for re-evaluation.
d. all of the above.

33. Who decides to medically retire an HIV-positive member?
a. the member's commanding officer
b. the Physical Evaluation Board
c. the examining physician
d. the member's detailer

34. An HIV-positive member may be
a. permanently retired based upon results of his/her initial medical evaluation.
b. promoted based on his/her performance and time-in-service.
c. retained on active duty if diagnosed with AIDS.
d. returned to his/her command in Spain if found fit for duty by a physician.

35. Active duty personnel who are HIV-positive
a. are re-evaluated every five years during their birth-month physical.
b. return to one of three Navy hospitals for re-evaluation every 6 months.
c. can select a civilian HIV physician if approved by the CNO.
d. must take annual leave for medical re-evaluation since no one else in the command is allowed that much time off.

36. Attrition of personnel due to HIV infection can result in
a. increased training costs.
b. less efficient team work.
c. lower level of experience/expertise in commands.
d. all of the above.

37. Deployed Navy personnel may develop AIDS after exposure to
a. HIV-1, clade E
b. HIV-2
c. Both a. and b.
d. Syphilis

38. Which of the following statements is FALSE?
The goals of SHARP are to
a. maintain a database of HIV-infected Navy personnel.
b. inform personnel about HIV and STDs.
c. teach skills to reduce unplanned pregnancies among personnel.
d. Promote responsible sexual decision making.